Complete Summary

GUIDELINE TITLE

The role of HPV testing. In: Canadian consensus guidelines on human papillomavirus.

BIBLIOGRAPHIC SOURCE(S)

Provencher DM, Murphy KJ. The role of HPV testing. In: Canadian consensus guidelines on human papillomavirus. J Obstet Gynaecol Can 2007 Aug;29(8 Suppl 3):S15-21. [66 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Human papillomavirus infection of the uterine cervix

GUIDELINE CATEGORY

Diagnosis
Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Infectious Diseases

Internal Medicine
Obstetrics and Gynecology
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To promote guidelines for health care providers on the key aspects of human papillomavirus (HPV) infection and the management of HPV-related disease in the new era of vaccine availability

TARGET POPULATION

Sexually active women and adolescent girls, and sexually abused children

INTERVENTIONS AND PRACTICES CONSIDERED

Human papillomavirus DNA testing

MAJOR OUTCOMES CONSIDERED

Incidence of human papillomavirus infection

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Medline and Cochrane databases were searched for articles from January 1995 to March 2007 on subjects related to human papillomavirus (HPV) infection, HPV vaccination, HPV-related disease, Pap testing, and specific consideration of management.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort (prospective or retrospective) or case–control studies, preferably from more than one center or research group.

II-3: Evidence obtained from comparison between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

* The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

All study types were reviewed. Randomized controlled trial results were considered evidence of the highest quality, followed by results of cohort studies. Key individual studies on which the recommendations are based are referenced.

Supporting data for each recommendation were summarized with evaluative comments and references.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Classification of Recommendations* †

A. There is good evidence to recommend the clinical preventive action

B. There is fair evidence to recommend the clinical preventive action

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making

D. There is fair evidence to recommend against the clinical preventive action

E. There is good evidence to recommend against the clinical preventive action

I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

*Woolf SH, Battista RN, Angerson GM, Logan AG, Eel W. Canadian Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. Can Med Assoc J 2003;169(3):207-8.

† Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

COST ANALYSIS

A formal cost analysis is included in *Chapter 7: Cost-Benefit Analysis of HPV Vaccination* in the original guideline document.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

These guidelines were prepared by the human papillomavirus (HPV) Consensus Guidelines Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The grades of recommendations (A-E and L) and levels of evidence (I, II-1, II-2, II-3, and III) are defined at the end of the "Major Recommendations" field.

1. Reflex human papillomavirus (HPV) DNA testing is recommended only for women aged 30 years or more with atypical glandular cells of undetermined

significance (ASCUS) and should be used only as an adjunct to cervical cytology, to reduce the false-positive rate of conventional cytology and increase the negative predictive value of testing. **IA**
2. There is no indication for HPV testing in women younger than 30 years and therefore it should not be done. **IA**
3. Because of the high prevalence of high-risk HPV types in women with low-grade squamous intraepithelial lesion (LSIL), high-grade squamous intraepithelial lesion (HSIL), and squamous cell carcinoma (SCC), triage by means of HPV testing should not be done. **IA**
4. More research should be done to better characterize natural and acquired immunity after HPV infection and vaccination and to redesign screening strategies to focus on identifying women with persistent infection. **IIIA**

Definitions:

Levels of Evidence*

I: Evidence obtained from at least one properly randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case–control studies, preferably from more than one center or research group.

II-3: Evidence obtained from comparison between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

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Grades of Recommendations*†

A. There is good evidence to recommend the clinical preventive action

B. There is fair evidence to recommend the clinical preventive action

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making

D. There is fair evidence to recommend against the clinical preventive action

E. There is good evidence to recommend against the clinical preventive action

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CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate testing for human papillomavirus (HPV) infection
- Prevention of the spread of HPV infection

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This document reflects emerging clinical and scientific advances on the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Aug

GUIDELINE DEVELOPER(S)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

SOURCE(S) OF FUNDING

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GUIDELINE COMMITTEE

HPV Consensus Guidelines Committee

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Disclosure statements have been received from all members of the committees.

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Canadian Association for Adolescent Health - Medical Specialty Society
Canadian Pediatric and Adolescent Gynaecology and Obstetrics Committee - Medical Specialty Society
Federation of Medical Women of Canada - Professional Association
Quebec Association of Pediatricians - State/Local Government Agency [Non-U.S.]
Society of Canadian Colposcopists - Professional Association
Society of Gynecologic Oncologists of Canada - Disease Specific Society

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Society of Obstetricians and Gynaecologists of Canada Web site.

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on July 6, 2009. The information was verified by the guideline developer on July 14, 2009.

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